To: Regional General Managers
District General Managers
Copy: FHSA General Managers
NHS Trust Chief Executives
Directors of Social services - for information

NHS Management Executive

Department of Health
Quarry House
Quarry Hill
Leeds LS2 7UE
Telephone 0532 545000 ext
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EL(94)14
18 February 1994

Dear Colleague,

Contracting for specialist palliative care services

1. This letter gives guidance to health authorities on funding for, and the purchase of, specialist palliative care services in 1994/95.

2. You will now have received your financial allocations for 1994/95. Separately identified within Initial Cash Limits are:

£35,700,000	funding for hospices (incorporated in Regional baselines)
£5,720,000	DSS transfer for voluntary hospices (incorporated in baselines) and
£6,309,000	drugs for voluntary hospices (Distributional adjustment to General Allocation).

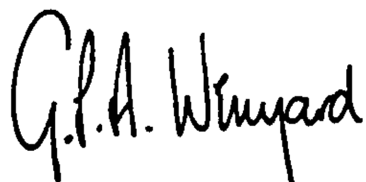
These three budget lines cover the funding which, in previous years, was top-sliced in order to provide financial support to the voluntary hospice sector.

3. Regions are asked to:

- ensure that purchasing authorities have appropriate service contracts for specialist palliative care for the new financial year no later than 1 April 1994 as required in EL(93)54;
- publish within 3 months of the date of this letter a summary of these contracts;
- follow the guidance in **Annex B** on the drugs for hospices scheme;
- follow the guidance in **Annex C** on the use of the £5.72m DSS transfer;
- provide the monitoring return at **Annex D** to the Department of Health *no later than 30 September 1994*; and
- provide the monitoring return at **Annex E** to the Department of Health *no later than 31 July 1994*.

4. Enquiries about the content of this letter should be addressed to Miss Susan Row, Room 528, Eileen House, Newington Causeway, London SE1 6EF (Tel: 071 972 2816). The completed monitoring returns should be returned to Mrs Lisa Westall, Room 515 at the same address.

Yours sincerely,



Dr Graham Winyard
Medical Director
NHS Management Executive

This letter will be cancelled on 1 April 1996

Purchasing specialist palliative care services 1994/95

Allocations

1. The allocation of funds to each Region for 1994/95 is based on the estimated distribution of population in the 65-84 age group, and is as follows:

Region	Amount (£000)
Northern	2,308
Yorkshire	2,710
Trent	3,498
East Anglian	1,679
North West Thames	2,358
North East Thames	2,624
South East Thames	2,906
South West Thames	2,304
Wessex	2,426
Oxford	1,646
South Western	2,805
West Midlands	3,772
Mersey	1,747
North Western	2,917
Total	**35,700**

Contracts for specialist palliative care services

2. This funding is intended for the purchasing of specialist palliative care services (see paragraph 7 below) to meet locally identified health needs and replaces funding previously top-sliced. EL(93)54 made it a priority for RHAs for 1994/95 to ensure that "an appropriate level of palliative care services for terminally ill people is commissioned through service contracts.".

3. Regions will wish to move towards allocating funding to purchasing authorities on the basis of weighted capitation at a pace which pays due regard to existing patterns of palliative care provision. In laying contracts for specialist palliative care in 1994/95, purchasing authorities will wish to ensure that the high quality of service provided at present by established specialist palliative care units and services, including the voluntary hospice sector, can be maintained.

4. In purchasing specialist palliative care, authorities should have regard to the totality of funding available to them, and not solely to their share of the funding separately identified for specialist palliative care as shown above. Many authorities already fund NHS specialist palliative care provision; in addition, a number of authorities have, in previous years, used a part of their general allocations to contribute towards funding specialist palliative care provided by the voluntary sector. Existing levels of support should, wherever possible, be maintained.

5. Where a hospice or specialist palliative care community service serves more than one authority, it may be helpful to agree a contract through a consortium arrangement or lead purchaser, as recommended in EL(93)14.

6. Separately identified funding is *not* intended to be used to meet existing commitments made by authorities to take over the funding of nursing services provided with 3 year pump-primed funding from the Cancer Relief Macmillan Fund, and the NHS contribution already committed to Marie Curie Cancer Care Nursing services.

7. *Specialist palliative care* for terminally ill people is defined by the National Association of Health Authorities and Trusts as:

> "active total care when disease is not responsive to curative treatment. Palliative care neither hastens nor postpones death; provides relief from pain and other distressing symptoms; integrates the psychological and spiritual aspects of care; offers a support system to help the family cope during the patient's illness and in bereavement."

It may be provided in an in-patient unit, or in a day care or home setting, and should be available without regard to the individual's diagnosis.

8. *Terminally ill people* are those with:

> "active and progressive disease for which curative treatment is not possible or not appropriate and from which death can reasonably be expected within 12 months".

9. The National Council for Hospice and Specialist Palliative Care Services is currently working with professionals in the field to develop more detailed definitions for palliative care. Once available, these definitions will be circulated to the NHS and voluntary sector providers.

Local strategies for specialist palliative care

10. The development of hospice care has been dependent on the initiative of the voluntary sector and this has resulted in uneven provision. Purchasing authorities have a duty to ensure that the identified health needs of the population they serve are met. This applies equally to the special needs of terminally ill people. Health authorities should, therefore, develop local strategies for specialist palliative care based on needs assessment in collaboration with other relevant local bodies and palliative care providers, including the voluntary sector. Regions should ensure that new service developments form an essential part of the overall strategy, and do not compete with existing high quality services. Authorities should aim to achieve a broad equivalence of service across the Region.

Communication

11. Communication between purchasing authorities and palliative care providers is essential in order to ensure agreement of service contracts and to develop local strategies for specialist palliative care. Consultation with regional representatives to the National Council for Hospice and Specialist Palliative Care Services is, therefore, advisable. Providers should, therefore, co-operate in providing the information which purchasers need to assess quality of service and cost-effectiveness, and to monitor service contracts. Purchasing authorities should ensure that providers are aware of local purchasing priorities and local identified health needs.

12. Regions should publish locally to providers and other interested parties particulars of the allocation of this funding to purchasing authorities *within 3 months* of the date of this letter, and notify the Department of Health.

Future arrangements

13. After this year, funding for hospices/specialist palliative care will cease to be separately identified. The sums set out in paragraph 1 will, therefore, be built into recurrent baselines. The NHSME will continue to monitor authorities' performance in laying contracts to ensure the provision of appropriate palliative care services to meet the needs of their populations. We expect authorities to agree 3 year contracts wherever possible, in order to ensure stability of funding and service provision.

Monitoring

14. Purchasers' performance in purchasing palliative care services for their populations will be monitored closely by the NHS Management Executive through the performance management process. Full, accurate and timely feedback on current and future funding is essential. Regions should, therefore, complete and return the proforma at Annex D **no later than 30 September 1994.**

The supply of drugs to hospices

Introduction

1. This scheme, which has been in operation since April 1991, was reviewed in 1993. Ministers accepted the Review's recommendation that the supply of drugs and items listed in part IX of the Drug Tariff to voluntary hospices free of charge through health authority contractual arrangements with community and hospital pharmacists should continue after 31 March 1994.

2. This Annex gives general guidance on arrangements for this scheme in 1994/95. The review had also recommended the provision of good practice professional guidance for the NHS and voluntary hospices; this guidance is currently being developed in consultation with NHS, voluntary sector and pharmaceutical colleagues and will be issued separately.

Allocations

3. The funds for each Region for 1993/94 are based on the national average cost per bed and distributed to Regions pro-rata to the forecast number of voluntary hospice beds (except for the specialist AIDS hospices in North West Thames, North East Thames and South East Thames). These funds have been allocated in line with expected expenditure.

Region	Amount (£000)
Northern	324
Yorkshire	641
Trent	259
East Anglian	219
North West Thames	460
North East Thames	753
South East Thames	624
South West Thames	478
Wessex	251
Oxford	222
South Western	456
West Midlands	480
Mersey	452
North Western	690
Total	**6,309**

Use of funds

4. The funds identified above should be used to contribute to:
   - costs incurred by HAs in arranging for drugs to be supplied free of charge to hospices for their use in treating patients for whom the hospices have clinical responsibility;
   - costs of supplying dressings, appliances and chemical reagents listed in Part IX of the Drug Tariff to those hospices who would otherwise be obliged to purchase them because the FP10 route is not open to them; and
   - associated professional costs.

5. These funds are **not** intended to be used to contribute to:
   - costs incurred by HAs in pursuance of statutory obligations; or
   - the reimbursement of direct expenditure by hospices.

6. Under this scheme:
   - a **hospice** is a registered nursing home, managed by a voluntary organisation, which provides specialist palliative in-patient care for terminally ill people.

Contractual arrangements

7. HAs will continue to be responsible for securing contracts between eligible hospices and suppliers (hospital or community pharmacies) situated in their districts for the supply of drugs and, where relevant, items listed in part IX of the Drug Tariff. The contractual arrangements should enable hospices to obtain stock drugs and professional advice on the use of medicines. Subject to agreement on the items and services to be supplied, and the application of appropriate cost and quality controls, the HA should arrange for designated suppliers to make these supplies without charge to the hospice.

8. Hospices participating in this scheme will be expected to co-operate in providing such information as HAs may reasonably require to monitor its operation.

VAT

The supply of medicinal products to a hospice may be zero-rated provided it is a registered charity and it issues a certificate of zero-rating. The paperwork required will depend on the structure of the contractual arrangements. HA enquiries about VAT should be addressed to:

HM Customs and Excise
VAT Administration Division H, Branch 2,
New Kings Beam House
22 Upper Ground
LONDON SE1 9PJ.
(Tel: 071 865 5866)

Use of FP10s

10. It should not normally be necessary for a general medical practitioner (GP) to prescribe drugs on form FP10 for a patient who has been admitted to a hospice unless, exceptionally, the item required is not in stock and cannot otherwise be supplied without unacceptable delay. GPs may continue to prescribe Drug Tariff items other than drugs on Forms FP10 for patients on their lists.

Statutory requirements

11. This scheme does not affect in any way the obligations of hospices nor of health authorities in relation to the Registered Homes Act 1984 and the Misuse of Drugs Act 1971 and to Regulations made under these Acts.

Future arrangements

12. It is intended that the drugs for hospices scheme will continue to be based on the national average cost per bed and distributed to HAs pro-rata to the forecast number of voluntary hospice beds, with an adjustment for the specialist AIDS hospices. *These funds should, therefore, continue to be separately identified within HAs' main allocations.*

Monitoring

13. Although HAs are expected closely to monitor the local operation of this scheme, the NHS Management Executive will continue to require monitoring returns on estimated expenditure and accurate forecasts of voluntary beds. As the distributional budget for 1995/96 should be based on the information in these monitoring returns, Regions are requested to complete and return the proforma at **Annex E no later than 31 July 1994.**

Income support transfer

Introduction

1. This guidance covers the allocation of £5.72 million transferred from the Department of Social Security (DSS) in consequence of the removal of eligibility for income support payments for people entering hospices. This funding should be used by authorities to maintain levels of public funding for in-patient voluntary hospices. This transfer will rise to £6m in 1995/96.

Allocations

2. The allocation of funds to each Region for 1994/95 is based on weighted population and is as follows:

Region	Amount (£000)
Northern	380
Yorkshire	437
Trent	547
East Anglian	231
North West Thames	422
North East Thames	487
South East Thames	470
South West Thames	363
Wessex	348
Oxford	260
South Western	387
West Midlands	606
Mersey	290
North Western	492
Total	**5,720**

3. This money has been transferred to health authorities specifically to maintain levels of public funding available for hospices and should only be used to pay for the specialist in-patient care of terminally ill people. Regions are asked to allocate the money to purchasers in a manner which reflects historical reliance on Income Support of hospices in their areas.

Use of funds

4. In allocating funding to hospices, authorities should try to ensure that voluntary hospices who previously received some income support funding do not face a significant reduction in income which could damage patient care. Funding should be provided through contractual arrangements.

5. These funds are **not** provided to contribute to:

- the costs of residential care for people who do *not* require specialist palliative care;
- general running costs unrelated to services;
- care in NHS units;
- services other than in-patient hospice care provided by voluntary organisations specialising in palliative care (such as home nursing and night sitting services or bereavement counselling/ support).

6. Under this scheme:

- an *eligible organisation* is a voluntary hospice or a nursing home which provides specialist palliative care for residents who are terminally ill;
- a *hospice* is a registered nursing home managed by a voluntary organisation which provides specialist palliative in-patient care for terminally ill people;
- *terminally ill people* are those with an active and progressive disease for which curative treatment is not possible or not appropriate, and whose death can reasonably be expected within 12 months.

Funding arrangements

7. Regions should use local discretion in allocating funding down to purchasers. In doing so, they should attempt to reflect the distribution of hospices, and ensure that purchasers are aware of past use of Income Support payments.

Future arrangements

8. The sums set out in paragraph 2 will be built into Regions' recurrent baselines. The continued development of close liaison and contractual arrangements between HAs and voluntary hospices is vital for the provision of flexible and responsive services for patients requiring specialist palliative care.

Monitoring

9. The NHS Management Executive will monitor use of this funding through the Performance Management process. Regions will be expected to be able to demonstrate that this money is being used for the purpose detailed above and that the money has been allocated in a way which enables individual hospices to continue to provide a range of high quality specialist palliative care services for NHS patients.

Community care

10. EL(93)14, which gave guidance on the use of this funding for 1993/94, set out how the NHS's responsibilities for securing palliative care would be affected by the introduction of the new arrangements for community care. This guidance still applies. In particular health authorities may wish to note:

- where assessment reveals that a person is terminally ill and requires specialist in-patient or respite palliative care, it will be for the health authority to arrange that, whether in a voluntary hospice, NHS facility or independent sector nursing home capable of providing such care.
- where an individual has been placed in a nursing home or residential care home by a local authority, who at the time of the initial assessment and placement was not in need of specialist in-patient care but comes in time to require such care, health authorities will be responsible for providing such additional specialist care. Broadly, health authorities would be expected to provide specialist palliative care to people in residential care homes as if they were living at home and in nursing homes to provide any necessary *additional* specialist palliative health care in addition to general nursing (which will continue to be included in the local authority's contract with the home). Specific arrangements for this should be agreed locally between health and local authorities. Local discussion and agreement are the key to seamless and responsive care.

Purchasing palliative care: return for ....District
Table 1 - planned funding for 1994/95

Unit[1]	Total revenue expenditure of provider unit[2]	funding from specified allocation[3]	funding from other NHS resources[4]	Other information[5]

Notes on completion

1. Show name and location of each specialist palliative care provider (specifying whether NHS or voluntary unit) for whom funding is being provided through contractual arrangements. If funding is being provided through means other than a contract, please give details.
2. Show, where known, the total revenue expenditure for the unit for 1994/95.
3. Show here use of centrally specified funding in contracting for specialist palliative care services.
4. Show here use of general allocations in addition to separately centrally identified funding used to contract for specialist palliative care services.
5. Show here any other relevant information including NHS capital, money provided under Annex C to this EL, and the cash equivalents of support in kind.

Additional Information

1. Regions should give an account of steps taken or proposed to ensure that purchasing authorities have agreed service contracts with hospices and other eligible organisations for specialist palliative care services.

2. Regions are asked to submit a brief narrative summarising improvements in the quality of care achieved in the last 12 months and any new service developments planned or initiated.

3. Please send returns by **30 September 1994** to Mrs Lisa Westall, Room 515 Eileen House, Newington Causeway, London, SE1 6EF.

The supply of Drugs to Hospices: return for .... Region

Voluntary managed hospice in-patient unit			1994/95 estimated expenditure on supplies and services provided through the scheme including associated professional costs*
Name	No. of beds included in the scheme		
	1994/95	1995/96 forecast	
Total			

- * These should include expenditure on drugs and items listed in part IX of the Drug Tariff

Please send returns by **31 July 1994** to Mrs Lisa Westall, Room 515, Eileen House, Newington Causeway, London, SE1 6EF.